

OFFICIAL

- b. This budget will be reviewed by the Administering Agency, adjusted if necessary, and when approved, will serve as a basis for the service payment rate and the calculation of the actual cost rate. Providers will be required to adhere to their approved budget. Expenditures which are in excess of allowable budgetary limits will be reimbursable. Allowable budgetary limits are defined as the approved line item amount plus 10% or \$500.00, whichever is greater. Under no circumstances, however, will the total of allowable costs exceed the approved total net cost. If a provider foresees costs exceeding allowable budgetary limits, he may apply to the Administering Agency for a budget amendment. Such request must state justification for the change. Costs, in excess of the allowable budgetary limits, incurred prior to approval by the Administering Agency will not be reimbursable.
- c. The service payment rate will be determined by dividing the net cost by the estimated patient days. The provider must indicate the number of certified beds and must estimate patient days based on past experience and known changes, but in no case may estimated patient days indicate an occupancy of less than 85%.

7.5.2 Exceptions to the Budgetary Process

- a. State Agencies - State agencies which operate ICF/MR facilities and submit biennial budgets for legislative approval shall be exempt from the budgetary process. For these providers, the service payment rate will be calculated in accordance with the budget as approved by the Legislature. The actual cost rate will be determined in accordance with Paragraph c. of the above section of these regulations, except that budgetary constraints will not be imposed.
- b. New Facilities - New facilities will be subject to Paragraph c., above, with the exception that budgets will be derived only from projections of operations for the ensuing fiscal year. New facilities will have the option of having the service payment rate adjusted quarterly if they can substantiate that the service payment rate is not within 10% of the actual cost rate. New facilities are defined as those which have not completed one full fiscal year of operation.
- c. Loss or Abandonment - Loss on the sale or abandonment of fixed assets may be submitted for consideration after incurrence, but such submission must be within ten days of determination of loss.

7.5.3 Allowance for Known Cost Changes - Future cost increases or decreases, known as of the budget filing date, must be taken into consideration in the budget preparation process. Cost increases will be considered only when they meet the criteria for allowability as defined in the Allowable Costs section of these regulations, and the following requirements:

OFFICIAL

- a. Salary and wage changes must be based on changes in effect at the end of the current period and/or future changes substantiated by labor contracts, board resolutions, written policies, or minimum wage laws.
- b. Changes in facility costs will be based on changes in effect at the end of the current period and/or future changes substantiated in the budget narrative.
- c. The cost effects based on the need to change program services must be accompanied by justification of, and need for, such change.
- d. Cost changes may be justified by references to pertinent Federal, State, or local laws and regulations.
- e. Cost changes in all line items not specifically outlined above must be justified by referring to cost changes during the last completed fiscal quarter prior to the budget submission date plus consideration of reasonable increases expected to occur during the budget period.

7.5.4 Written Notification - The Administering Agency will provide written notification of the proposed service payment rate or the actual cost rate within ten days of its determination of such rate. Notification will include the method used in determining such rates and the method of submitting comments from the public to the Administering Agency. The posted, or an adjusted rate, shall become final on the tenth day following the date posted in the notification for receipt of comment.

7.6 Payment Mechanisms

Payments are made to providers from the Department of Mental Health. Providers must submit a properly completed form to:

Department of Social Welfare
Medical Services Division
Waterbury Office Complex
Waterbury, VT 05676

A copy of this form and instructions for completion are attached. Providers should expect payment for verified services within four weeks of mailing completed forms. Providers will receive a form listing any adjustments made to the billings. Information regarding the processing of any claims may be obtained from the Department of Mental Health at 241-2600. The provider will be reimbursed on a monthly basis during its fiscal year at the service payment rate, but no payment will be initiated prior to receipt of required reports. Reimbursement adjustments based on the actual cost rate will be determined within thirty days of receipt of an acceptable audit. If the determination requires a payment to the provider, payment shall be initiated within thirty days after the date of final determination. If the determination requires a repayment from the provider, the provider must make such repayment within ninety days of the final determination.

7.7 Service Payment Rate

The service payment rate will be based upon the total net costs of the

OFFICIAL

approved budget divided by the estimated resident days. The Administering Agency reserves the right to revise this rate at any time if the rate seems substantially inconsistent with the actual allowable costs.

7.8 Actual Cost Rate

The actual cost rate will be calculated by dividing the allowable costs for the fiscal year, in accordance with the budgetary provisions of the Rate Determination section of these regulations, actual resident days, except if actual resident days are 85% or less of maximum occupancy, 85% occupancy will be used to calculate the actual cost rate. Furthermore, the Administering Agency will require an annual audit (by a qualified person or firm, not connected with the provider), to determine the fairness of the actual cost rate. The Administering Agency may, at its option, provide said audit.

7.9 Record Keeping

7.9.1 All providers receiving Medical Assistance payments for ICF/MR's must meet the following financial accountability requirements:

- a. All records must be maintained on a full accrual basis, excepting State agencies shall use a modified cash system approved by the Commissioner of Finance.
- b. All non-allowable costs under the services provision in the Non-allowable Costs section of these regulations must be physically segregated (i.e., a separate set of financial records) from allowable costs, or if intermixed with allowable costs, must be readily identifiable for audit purposes. Costs eligible under the provisions of Part H of the Allowable Costs section of these regulations, that readily identify the basis for distribution, meet this condition.
- c. All financial records must be maintained in accordance with generally accepted accounting principles and must provide a clear audit trail.
- d. All reports required in the Reports section of these regulations will be subjected to a desk audit and may be subjected to a field examination of supporting records and compliance with regulations. If such audits reveal inadequacies in provider record keeping and accounting practices, the Administering Agency may require that the provider engage competent professional assistance to properly prepare the required reports.
- e. Clinical records must be maintained in the manner prescribed in the ICF/MR Operating Regulations, and must provide a means of readily identifying the number of resident days. All records and reports pertaining to financial transactions must be maintained by the provider for not less than three years from the date of the submission of an approved audit for the period to which the material pertains.

7.10 Reports

7.10.1 Required Reports - In order to receive reimbursement at the service

OFFICIAL

payment rate, the provider must submit a monthly report, in the format prescribed by the Administering Agency. The report must include cumulative revenue and expenditures according to budgetary line items, an invoice for the units of service rendered, and/or any other data relevant to justification or support of the Medical Assistance rate as deemed necessary by the Administering Agency.

- 7.10.2 Report Deadlines - All provider reports shall be submitted no later than the 30th of the month following the month being reported. Reports received after this date, and reports received in unacceptable condition, will be subject to at least a thirty day payment delay.
- 7.10.3 Report Certification - Reports must be certified, in the place indicated, by signature of the operating executive.
- 7.10.4 False Reports - False information knowingly supplied by the provider on a required report will result in termination of the provider's contractual agreement and/or prosecution under the applicable Federal and State statutes.
- 7.10.5 Amended Reports - Providers must file amended reports immediately upon discovery of any errors in the number of units of service billed. If an error is discovered in the financial reporting, appropriate adjustments must be made the succeeding month.
- 7.10.6 Audits - An audit will be conducted annually in accordance with provisions of the Actual Cost Rate section of these regulations. Reports will be submitted to the Administering Agency not more than five months after completion of the fiscal year.

7.11 Absence From Facility

Notwithstanding any other provision of these regulations, nothing herein shall be interpreted as an impediment to having ICF/MR residents: a) visit with family, friends, or other significant persons; or, b) be away from the facility for social, recreational, or related purposes, provided that all visitations and/or absences for which Title XIX reimbursement is sought are consistent with, and part of, the resident's current habilitation plan.

There shall be no limit to the number of such visitation/absent days per year. However, in the event that a resident's habilitation plan provides for visitations/absences in excess of fifteen (15) days per quarter or sixty (60) days per annum, approval for such excess days shall be obtained in advance from the Commissioner of Mental Health.

The Department shall not withhold such approval unless:

- a. The resident's habilitation plan does not specifically provide for the amount of visitation/absence requested.
- b. The extent of visitation/absence suggests that continued ICF/MR placement is inappropriate.
- c. The resident's habilitation plan is not current or has not been reviewed in accordance with facility policy.

OFFICIAL

7.12 Appeal Procedures

- 7.12.1 Scope of Appeal Procedure - These procedures describe the manner by which unresolved individual provider disputes concerning application of these regulations shall be settled. Unresolved disputes are defined as those disagreements that cannot be resolved between the provider and the Administering Agency. Such disputes may be appealed by the provider.
- 7.12.2 Appeal Procedure - An appeal shall be submitted in writing to the Vermont Human Services Board and shall include facts, arguments, and other pertinent data. Appeals shall be heard by the Appeals Examiner who shall be an impartial party designated by the Board.
- 7.12.3 Time Limit - The provider has thirty days from the date of the Administering Agency's final determination of the matter disputed to initiate formal appeal.
- 7.12.4 Settlement Mechanism - If the appeal is related to a change in the provider's rate, the amount in dispute will not be adjusted until final determination according to the appeal procedure is made. If the appeal determination requires a payment to the provider, payment shall be initiated within thirty days after the date of final determination. If the appeal determination requires repayment from the provider, the provider must make such repayment within ninety days of the final determination.
- 7.12.5 Findings and Conclusions - Any findings, conclusions, or opinions of the Appeals Examiner about any appeal will be made available to the provider and to the Administering Agency.

OFFICIAL
OFFICIAL

ANTON J. COLLINS, JR.
REGIONAL ADMINISTRATOR
PROGRAM OPERATIONS

(SNF/ICF - EXCEPT SNF/IR)

84-15
Attachment
4.19-1

In accordance with 42 CFR 447.252(a) and (b), and consistent with 447.253(g), the Vermont Medicaid Program, effective for services provided on or after July 1, 1984, will pay for long term care facility services in Skilled Nursing Facilities and Intermediate Care Facilities under the Methods, Standards and Principles for Establishing Payment Rates. Rates calculated under such Methods, Standards and Principles have been determined by the State to be reasonable and adequate to meet the cost incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. The Vermont Agency finds that such payment meets the requirements of 42 CFR 447.253(b)(1)(1).

Allowable rates of reimbursement are determined by applying an inflation factor for the ensuing rate year to prospective rates (such prospective rates based on 1981 actual allowable costs of each facility, determined in accordance with HIM-15 principles and methods). Such reasonable and adequate rates will continue to be increased each July 1 by an inflation factor sufficient to enable efficiently and economically operated facilities to provide care in conformity with applicable Federal and State requirements. The inflation factor for the rate period ending July 30, 1985 is 5.1 percent.

The State Agency provides for uniform cost reporting and periodic audits as specified in 42 CFR 447.253(d) and 447.253(e). All participating facilities must file an annual uniform cost report within 90 days after the end of their fiscal year. (See Attachment A for the uniform cost report). Full scope on-site field audits of the financial and statistical records are conducted on at least 20 percent of the facilities each year.

Supersede 82-15

OFFICIAL

-2-

OFFICIAL

84-15

The State of Vermont has complied with the public notice requirements in 42 CFR 447.205 as specified in 42 CFR 447.253(f). A public announcement was published in the major daily newspapers on April 12 and April 19, 1984 advising all interested parties of a public hearing that was held on May 1, 1984 regarding the attached amendment to the Plan.

The public hearing was attended by 24 interested persons, including facility representatives and employees, and representatives of trade associations. Three individuals presented oral testimony, and a few additional written comments were received and considered subsequent to the public hearing.

As specified in 42 CFR 447.253(c), the State Agency has provision for individual providers to submit additional evidence and receive prompt administrative review of payment rates and other final orders affecting payments. Beyond the specific appeal provisions of the payment Methods, Standards and Principles, individual providers have a further right of administrative appeal and hearing before an independent hearing officer under provisions of Title 33, Vermont Statutes Annotated.

In accordance with 42 CFR 447.253(b)(2), the State Agency has made a finding that the aggregate Medicaid payments will not exceed the amount that would be paid for the services utilizing the Medicare Principles of Reimbursement, adjusted for services not included in the State Plan, and for services in the Medicaid Program not included in the Medicare Program. Although not required by Federal regulations, the payment Methods, Standards and Principles continue to require that the Medicaid payment not exceed customary charges to the general public for such services.

In accordance with the provisions of 42 CFR 447.255, the State Agency submits the following information:

Supersedes 82-15

Individual rates of reimbursement are determined by applying an inflation factor to each facility's prospective rate on June 30 (exclusive of property costs and return on equity, which are based on actual costs determined in accordance with this plan). For a more detailed description, see the revised Section 401 of the Methods, Standards, and Principles for Reimbursement to Skilled Nursing and Intermediate Care Facilities.

The average SNF/ICF payment rate for the rate year ending June 30, 1985 will be \$50.32, an increase of 5.0 percent over the average rate for the immediately preceding rate period.

At the present time, 45 of the 47 facilities licensed as Skilled Nursing or Intermediate Care Facilities are participating in the Title XIX Medical Assistance Program. Since these Methods, Standards and Principles will result in increases each July 1, based on review of economic indicators, the present extensive participation on a statewide and geographic area basis is expected to continue, with no significant effect on the type of care provided. A limit at the 90th percentile of rates adjusted for inflation (exclusive of property and equity) effective July 1, 1985 is not expected to have any adverse impact on accessibility to and availability of services that meet quality and safety standards. Continued application of these Methods, Standards and Principles will assure the continued delivery of high quality care and the continued availability of services on a statewide and geographic basis to Skilled Nursing and Intermediate Care recipients under the Medicaid Program.

August 23, 1984

(Revised per Mr. Fuoroli's letter of ~~December~~ 12, 1984)

Revised 82-15

OFFICIAL

Form APA-5A

84-15

COVER SHEET FOR ADOPTED RULE

1. TITLE OR SUBJECT OF RULE: Nursing Home Rate Setting
2. AGENCY: Agency of Human Services
3. AGENCY'S REFERENCE NUMBER (If any): 82-22
4. SECRETARY OF STATE'S REFERENCE NUMBER FOR EARLIER PROPOSED RULE: 84-P19
5. THIS RULE TAKES EFFECT FROM July 1, 19 84 THROUGH _____
6. LIST SPECIFIC STATUTORY SECTIONS GIVING AUTHORITY FOR THIS RULE:

33 V.S.A. §194(C)
7. DOES THIS ADOPTED RULE CONTAIN A RULE BY REFERENCE? Yes ☐ No ☒
If yes, attach statement required by 3 V.S.A. Section 838(d).
8. SUMMARIZE CHANGES MADE TO THIS RULE SINCE IT WAS PROPOSED
(Attach additional sheets if necessary. If no change, write "None".)
Summary of changes to the original proposal:
 1. The inflation factor for FY1984 has been increased from 4.4 to 5.1 percent.
 2. Section 403 of the Rule has been amended to allow adjustment of a prospective rate in the event of necessary significant changes in mortgage interest costs.
 3. Section 401 D. of the Rule has been changed so that the operations per diem part of a facility's rate will not be reduced in FY1984 below the 1984 level.
9. HAVE THE ECONOMIC COSTS AND BENEFITS OF THIS RULE CHANGED SINCE IT WAS PROPOSED?
Yes ☒ No ☐
If yes, attach a new "Summary of Economic Impact" (Form APA2).

10. THE AGENCY COMPLETED PROCEDURAL REQUIREMENTS ON THESE DATES:

OFFICIAL

84-15

- | | |
|---|---------|
| A. Proposed rule filed with Interagency Committee on Administrative Rules | N/A |
| B. Proposed rule filed with Secretary of State | 3/30/84 |
| C. First publication | 4/12/84 |
| D. Second publication | 4/19/84 |
| E. Hearing date or dates (If applicable) | 5/1/84 |
| F. Deadline for filing comments | 5/8/84 |
| G. <u>Final</u> proposed rule filed with Legislative Council and Secretary of State | 5/22/84 |

11. CERTIFICATION BY ADOPTING OFFICER

I have reviewed this rule. To the best of my knowledge, we in the agency have complied with all requirements of 3 V.S.A. Chapter 25 and with the rules of the Secretary of State's office and the Legislative Committee on Administrative Rules issued under that chapter. This rule is the most advantageous method for achieving the regulatory purpose at the least cost.

Date: JUN 18 1984
 ("Adopting officer" is the official empowered by statute to issue the rule; must sign personally and cannot delegate.)

Signature: TSD Prince
 Name (Type or print): LLOYD F. NOVICK, M.D.
 Title: Secretary, Agency of Human Services

12. ATTACHMENTS:

- | | |
|---|---------------------------|
| <input checked="" type="checkbox"/> Summary of economic impact (Form APA-2A; if applicable) | <u>1</u> pages |
| <input type="checkbox"/> Incorporation by reference statement (Form APA-3A; if applicable) | <u> </u> page(s) |
| <input checked="" type="checkbox"/> Adopting page (Form APA-4A) | <u>1</u> page |
| <input checked="" type="checkbox"/> Text of rule | <u>2</u> page(s) |
| <input type="checkbox"/> Other: <u> </u> | <u> </u> page(s) |